NORTHERN HEALTH SERVICES

TASK FORCE REPORT

SEPTEMBER 1991

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THE UNIVERSITY OF MANITOBA

FACULTY OF MEDICINE
Department of Community Health Sciences

750 Bannatyne Avenue
Winnipeg, Manitoba
Canada R3E 0W3

Tel: (204) 788-6711
FAX: (204) 774-8919

LETTER OF TRANSMITTAL (i)

September 16, 1991

Dr. J. Wade
Acting Chairman
Steering Committee
Health Advisory Network
C/O Room R1003
St. Boniface Hospital Research Centre
351 Tache Avenue
Winnipeg, Manitoba
R2H 2A6

Dear Dr. Wade,

On behalf of the Northern Health Services Task Force we are pleased to present our draft report to the Steering Committee of the Health Advisory Network. The recommendations are intended as practical and cost-effective solutions to health care delivery problems for Northern and Native Communities.

We would be pleased to discuss the draft report with you at your convenience.

Sincerely,

B.D. Postl, M.D., FRCPC
Co-Chairman

Mr. Bill Patmore
Co-Chairman

COMMITTEE MEMBERS

Co-Chair: Dr. Brian Postl
Community Health Sciences
University of Manitoba
S111-750 Bannatyne Avenue
Winnipeg, MB, R3E OW3

Co-Chair: Mr. Bill Patmore
316 Henry
Steinbach, MB, ROA 2A0

Members: Mr. Ed Campbell

House No. 85, Fort Island
Norway House, MB, ROB IBO

Ms. Elsie Crate
Fisher River
Koostatak, MB, ROC ISO

Dr. N. Jack Donaldson
Flin Flon Clinic
Box 160
Flin Flon, MB, R8A 1M8

Mr. Jim Goodridge
Keewatin Community College
436 7th Street East
The Pas, MB, R9A 1P7

Mr. Bill Ziprick (MHSC Board Liaison)
35 Clearwater Road
Winnipeg, MB, R2J 2T4

Ms. Flora Zaharia (Steering Committee)
59 Sage Crescent
Winnipeg, MB, R2Y OX8

Recording Secretary: Mr. Brian Gudmundson
Research & Planning
Manitoba Health
308-294 Portage Avenue
Winnipeg, MB, R3C OB9

I EXECUTIVE SUMMARY

The Northern Health Services Task Force was initiated in September 1989 by Manitoba's Health Advisory Network. Both northern and Native (province-wide) health concerns were to be addressed. The Task Force was requested to consider cost-effective means to expand the scope of health services in northern regional hospitals. Additionally, the Task Force was requested to recommend means to improve recruitment and retention of health care professionals in northern Manitoba, Norman Region and Thompson Region (see attached map).

The Task Force undertook a review process by examining previous reports, consulting with senior staff of Manitoba Health, M.H.S.C., and Medical Services Branch, Health & Welfare Canada. Input was also sought from the J.A. Hildes Northern Medical Unit, Department of Community Health Sciences and the Standing Committee on Medical Manpower. Correspondence was sent to all northern towns, community councils and 61 Status Indian Band Councils requesting contributions to the Task Force. In addition, the Task Force held meetings in a variety of northern communities to discuss local health care issues with board members, health care professionals and community representatives.

The Task Force observed that the health care utilization of Status Indians is significantly higher than non-Natives. It was noted that health care utilization of non-Native northerners approximates that of the province as a whole.

The Task Force also observed that the mandate to provide health care services and the delivery of health care services to Status Indians remains in some dispute. Disputes over jurisdiction for service delivery remain between the provincial and federal governments. An example is the absence of community mental health programs on Indian reserves.

The Task Force urged that populations suffering ill health must become primary stakeholders in the health care system that serves them. The Task Force identified the following key tennants to be undertaken:

* Expand the Pool of Native physicians;

* Maintain or Expand Northern Nursing Programs to meet northern needs;

* Expand the Availability of Community Mental Health Services;

* Establish a Formal Tripartite Committee to Deal with Implications (e.g. greater fiscal demands upon the province) of "Transfer of Control" of Local Health Services to Indian Bands;

* Establish Aboriginal Board Positions (proportional to local population) for Existing Health Care Facilities;

* Establish Employment Targets for Aboriginal People within Exisiting Health Services;

* Allow Aboriginal Healers to Work in a Complementary Fashion to Existing Health Services to Allow Access to Aboriginal Patients;

* Provide Native Interpreters/Advocates to Northern Health Care Facilities;

* Develop a Process for Regionalization of Health Care Services by Involving Local Stakeholders.

The specific recommendations (41) of the Task Force are as follows:

1. **IMPROVEMENTS IN HEALTH AND RELATED SERVICES TO NORTHERN MANITOBANS MUST BE A MULTISECTORAL RESPONSIBILITY. COORDINATION IN PLANNING AND SERVICE DELIVERY, AND RESOURCE ALLOCATION IS ESSENTIAL ACROSS THE MANY DEPARTMENTS, AGENCIES AND GOVERNMENTS INVOLVED.**

2. **THE TRANSFER OF CONTROL PROCESS IS IMPORTANT FOR ABORIGINAL PEOPLE AND SHOULD BE SUPPORTED FOR THOSE BANDS WHICH UNDERTAKE IT.**

3. **THE MANITOBA HEALTH SERVICES COMMISSION EXCLUDE THE NORTHERN ALLOWANCES COMPONENT FROM THE MANITOBA MEDICAL ASSOCIATION AGREEMENT.**

4. **THE MANITOBA HEALTH SERVICES COMMISSION RETAIN THE 10% NORTHERN ALLOWANCE FOR PHYSICIANS PRACTICING IN THE NORTH AS WELL AS ADD 0.5% PER YEAR FOR PHYSICIAN SERVICE IN THE NORTH.**

5. **THE MANITOBA HEALTH SERVICES COMMISSION PROVIDE HALF OF THE NORTHERN ALLOWANCE (e.g. 5%) FOR ITINERANT SPECIALISTS WHO SERVE NORTHERN RESIDENTS LOCALLY.**

6. **NORTHERN ALLOWANCES FOR OTHER NORTHERN HEALTH CARE PROFESSIONALS BE PROVIDED IN A SIMILAR FASHION AS FOR PHYSICIANS (SEE RECOMMENDATION #3).**

7. THE STANDING COMMITTEE ON MEDICAL MANPOWER BE ENCOURAGED TO DETERMINE THE PROSPECTIVE PHYSICIAN'S SPOUSES' GOALS AND ASPIRATIONS, AND ONCE DETERMINED, MAKE EVERY EFFORT TO ENSURE THAT SUCH CAN BE MET IN THE LOCATION BEING CONSIDERED.

8. SPECIAL PREMEDICAL STUDIES PROGRAM/PROFESSIONAL HEALTH PROGRAM MUST BE SUPPORTED TO FURTHER PRODUCE NATIVE PHYSICIANS TO ENHANCE THE CAPABILITIES OF THE PROVINCE IN PROVIDING CULTURALLY APPROPRIATE CARE TO A GROUP OF CITIZENS IN GREAT NEED.

9. THE FACULTY OF MEDICINE IMPROVE ITS EFFORTS TO RECRUIT STUDENTS FROM NORTHERN MANITOBA.

10. BURSARY PROGRAMS FOR NORTHERN STUDENTS BE DEVELOPED SO THAT THEY MAY ATTEND UNIVERSITIES AND COLLEGES WITHOUT ECONOMIC HARDSHIP.

11. THE GOVERNMENT OF MANITOBA MUST SUPPORT THE RURAL STREAM PROPOSAL OF THE FACULTY OF MEDICINE TO EXPAND THE EXPOSURE OF STUDENTS TO RURAL AND NORTHERN NEEDS.

12. THE FAMILY MEDICINE TRAINING PROGRAM SHOULD BE IMPLEMENTED IN DAUPHIN. ONCE THE EDUCATIONAL PROCESS CAN BE DOCUMENTED AS EFFECTIVE, THE FAMILY MEDICINE RURAL TRAINING PROGRAM SHOULD BE EXPANDED TO INCLUDE A SITE IN NORTHERN MANITOBA.

13. THE MANITOBA HEALTH SERVICES COMMISSION SHOULD CONTINUE TO DEVELOP ALTERNATE FUNDING SCHEMES AND INCENTIVES TO ATTRACT PHYSICIANS TO NORTHERN MANITOBA.

14. REFERRAL PATTERNS/MIX AND ACUITY BE EXAMINED BY CENTRE FOR HEALTH POLICY & EVALUATION, UNIVERSITY OF MANITOBA. IN THOSE AREAS WHERE SERVICE PROVISION IN THE NORTH APPROXIMATES COSTS OF TRANSPORT, SPECIALTY SERVICES AND REQUIRED SPECIALISTS SHOULD BE TARGETED FOR SPECIAL RECRUITMENT EFFORTS.

15. FOR THOSE SERVICES THAT CANNOT BE MADE AVAILABLE IN NORTHERN MANITOBA, A COMPREHENSIVE ITINERANT SPECIALIST PROGRAM SHOULD BE DEVELOPED CONSISTENT WITH SPECIFIC NEEDS OF NORTHERN MANITOBA AND ITS FACILITIES.

16. NORTHERN NURSING PROGRAMS FOR TRAINING NURSES FOR THE NORTH AND IN THE NORTH BE MAINTAINED OR EXPANDED.

17. MANITOBA HEALTH BE ASKED TO DO AN ANALYSIS OF THE SPECIFIC IMPACT IN THE NORTH FOR ENTRY TO PRACTICE AT A BACCALAUREATE LEVEL.

18. NURSES DO PROVIDE PRIMARY AND EMERGENCY CARE IN MANY REMOTE COMMUNITIES IN MANITOBA'S NORTH. THEY SHOULD BE RECOGNIZED FOR THESE FUNCTIONS.

19. ONCE RECOGNITION AND DEFINITION OF THE NURSE PRACTITIONER ROLE (MANITOBA ASSOCIATION OF REGISTERED NURSES) HAS BEEN DEVELOPED AND ACCEPTED, TRAINING AND MAINTENANCE OF COMPETENCE PROGRAMS MUST FOLLOW. THE CLINICAL NURSE TRAINING PROGRAM SHOULD BE A HIGH PRIORITY TO ENSURE THE PRESENCE OF CLINICALLY WELL TRAINED NURSES IN NURSING STATIONS. THIS PROGRAM SHOULD BE MADE AVAILABLE THROUGH EXISTENT EDUCATIONAL INSTITUTION OR INSTITUTIONS, AND SHOULD BE JOINTLY FUNDED BY BOTH LEVELS OF GOVERNMENT.

20. MANITOBA HEALTH SERVICES COMMISSION NEGOTIATE WITH NORTHERN HOSPITALS TO ENSURE ADEQUATE RECRUITMENT AND RETENTION OF NURSES. REMUNERATION, HOUSING, AND CONTINUING EDUCATION MUST ALL BE CONSIDERED TO ENSURE COMPETENT AND CONSISTENT NURSING COVERAGE. THE SPECIAL STRESSES AND DIFFICULTIES OF RECRUITING TO NORTHERN MANITOBA MUST BE RECOGNIZED IN THESE NEGOTIATIONS.

21. MANITOBA HEALTH SERVICES COMMISSION AS PART OF ITS PROGRAM PLANNING PROCESS MUST PROVIDE COMPREHENSIVE AVAILABILITY OF HEALTH PROFESSIONALS IN NORTHERN AREAS. IF SERVICES CAN BE VOLUME JUSTIFIED IN INDIVIDUAL INSTITUTIONS, TARGETED RECRUITMENT SHOULD BE ALLOWED. IF VOLUME CANNOT JUSTIFY FULL-TIME PARTICIPATION, ITINERANT SERVICES SHOULD BE FORMALLY AND SYSTEMATICALLY PROVIDED. THESE SERVICES SHOULD BE FUNDED THROUGH FACILITY BUDGETS.

22. ALL PROFESSIONAL FACULTIES MUST BE MORE AWARE OF THE NEEDS OF NORTHERN MANITOBA AND MAKE EFFORTS TO ENCOURAGE APPLICATION OF NORTHERN STUDENTS TO THEIR PROGRAMS.

23. COMMUNITY HEALTH WORKERS IN REMOTE COMMUNITIES BE PROVIDED WITH OPPORTUNITIES FOR CONTINUING EDUCATION AND BE PROVIDED WITH INCREASED SUPPORT OF ITINERANT NURSES.

24. THE NEED FOR MENTAL HEALTH PROFESSIONALS IN THE NORTH IS ACKNOWLEDGED AND LIKE OTHER MEDICAL/NURSING SPECIALTIES, TARGETED EFFORTS SHOULD BE DEVELOPED.

25. THE COMMUNITY MENTAL HEALTH PROGRAM BE EXPANDED SO AS TO PROVIDE A MORE COMPREHENSIVE SERVICE IN NORTHERN COMMUNITIES. THE TRAINING OF COMMUNITY MENTAL HEALTH WORKERS SHOULD BE SEEN AS A PROVINCIAL RESPONSIBILITY.

26. A STANDING TRIPARTITE COMMITTEE IN HEALTH BE ESTABLISHED INCLUDING THE PROVINCE, FEDERAL GOVERNMENT AND REPRESENTATIVES OF ABORIGINAL PEOPLES. THIS COMMITTEE SHOULD BE FORMALLY STRUCK WITH THE TASK OF IMPROVING COORDINATION AND COMMUNICATION.

27. THE 1964 AGREEMENT SHOULD BE RESCINDED BY BOTH LEVELS OF GOVERNMENT AND ALTERNATIVE ARRANGEMENTS EXPLORED THROUGH THE PROPOSED TRIPARTITE COMMITTEE.

28. THE PROVINCE OF MANITOBA AMEND THE DISTRICT HEALTH & SOCIAL SERVICES ACT AND ALL HOSPITAL ACTS TO LEGISLATE PROPORTIONATE BOARD REPRESENTATION BY ABORIGINAL PEOPLE ON HOSPITAL BOARDS. IN THOSE AREAS WHERE BED UTILIZATION BY ABORIGINAL PEOPLE IS DISPROPORTIONATELY IN EXCESS, ADDITIONAL BOARD SEATS FOR ABORIGINAL PEOPLE SHOULD BE PROVIDED.

29. THE MANITOBA HEALTH SERVICES COMMISSION ENCOURAGE FACILITIES TO DEVELOP EMPLOYMENT TARGETS FOR QUALIFIED ABORIGINAL PEOPLE ACROSS THE BREADTH OF THE WORKFORCE. THE ATTAINMENT OF THESE TARGETS SHOULD BE VERY CLOSELY MONITORED.

30. MANITOBA HEALTH SERVICES COMMISSION EXPLORE, THROUGH HOSPITAL BOARDS, MECHANISMS OF ENSURING ACCESS OF THE ABORIGINAL COMMUNITY TO ABORIGINAL HEALERS.

31. THE MANITOBA HEALTH SERVICES COMMISSION SHOULD, CONSISTENT WITH PATIENT LOADS AND THE NEEDS OF THE PATIENTS, FUND LARGE NORTHERN FACILITIES FOR FULL-TIME INTERPRETERS/ADVOCATES. THESE INDIVIDUALS SHOULD HAVE TRAINING IN THEIR ROLE.

32. IN SMALLER NORTHERN FACILITIES PERSONNEL SHOULD BE TRAINED AS PART-TIME INTERPRETERS/ADVOCATES, AS A PORTION OF THEIR OVERALL DUTIES.

33. THOMPSON SHOULD BE FURTHER DEVELOPED AS A REGIONAL CENTRE PROVIDED STAKEHOLDER COMMUNITIES ARE WILLING TO 'BUY IN'.

34. THE PAS AND FLIN FLON SHOULD ENTER INTO JOINT PLANNING OF SHARED SERVICES FOR THE NORMAN REGION.

35. THE DEPARTMENT OF HEALTH/MANITOBA HEALTH SERVICES COMMISSION MEET WITH REPRESENTATIVES OF ABORIGINAL COMMUNITIES TO DEVELOP LIAISON/BEGIN NEGOTIATIONS REGARDING EXPECTATIONS.

36. THE PROVINCE SHOULD CONSIDER THE POTENTIAL FOR TRANSFER OF CONTROL AS AN UNLOADING OF RESPONSIBILITY/COST FROM THE FEDERAL TO THE PROVINCIAL GOVERNMENT.

37. THE MANITOBA HEALTH SERVICES COMMISSION SHOULD UNDERTAKE A SENSITIVITY ANALYSIS OF THE FINANCIAL IMPACT OF TRANSFER. THESE FUNDS SHOULD BE CONSIDERED BY THE PROVINCE AS A FUNDING TRANSFER TO THEMSELVES AND UNDERTAKE NEGOTIATIONS WITH THE FEDERAL GOVERNMENT REGARDING POTENTIAL FOR OFFSETTING THIS TRANSFER.

38. THE PROVINCIAL GOVERNMENT SHOULD SEEK TO BECOME A PARTICIPANT IN FUTURE DISCUSSIONS BETWEEN BANDS AND FEDERAL GOVERNMENT REGARDING TRANSFER. AS THE TRUST RELATIONSHIP IS BETWEEN INDIAN AND FEDERAL GOVERNMENT THIS INVOLVEMENT MAY, BY NECESSITY, BE OBSERVER IN STATUS.

39. THE MANITOBA HEALTH SERVICES COMMISSION, IN CONJUNCTION WITH MEDICAL SERVICES BRANCH, EXPLORE MEANS FOR THE AIR AMBULANCE TO REPATRIATE STRETCHER PATIENTS FROM WINNIPEG HOSPITALS TO THE NORTH WHEN READY FOR TRANSFER OR DISCHARGE.

40. MANITOBA HEALTH SERVICES COMMISSION NEGOTIATE WITH GOVERNMENT OF THE NORTHWEST TERRITORIES THE POSSIBILITY OF SHARING THE GLOBAL FUNDING OF CHURCHILL HEALTH CENTRE AND IN REALLOCATING BOARD REPRESENTATION ON CHURCHILL HEALTH CENTRE BOARD TO MORE ACCURATELY REFLECT ITS ACTIVITIES.

41. IT IS ESSENTIAL THAT MANITOBA HEALTH SERVICES COMMISSION UNDERTAKE TO DEVELOP THEIR DATA SYSTEM TO BETTER IDENTIFY AND INCORPORATE THE NEEDS OF URBAN ABORIGINAL PEOPLE.

II TERMS OF REFERENCE

The Task Force on Northern Health Services shall review and make recommendations on the supply and organization of health care services in Northern Manitoba. The Task Force will undertake to:

Review as Background

1. Means to assist the Standing Committee on Medical Manpower (SCOMM) to fill reported physician vacancies.

2. Supply of other health professionals.

3. Problems of retention of health care staff.

4. Indian Health Care Services Sub-Committee Report: Volume III, Health Services Review Committee Report, 1985.

5. Implications arising from the federal initiative for "transfer of control" of local health care services to status Indian Band Councils.

6. Legislation pertaining to shared services.

7. Existing shared service agreements in northern communities.

Recommend

1. Means to improve physician recruitment and retention.

2. Means to improve other health professionals recruitment and retention.

3. Means to avoid duplication and fragmentation of Indian health care services.

4. Means to improve health service organization (e.g., shared services and/or altered governance).

5. Cost effective means to expand the scope of health services in northern regional hospitals which may reduce inter-hospital transfers to Winnipeg.

6. If and when appropriate, specify how to deal with new administrative structures or new service demands arising from the "transfer of control" initiative for status Indian Band Councils.

III TASK FORCE REVIEW PROCESS & CONSULTATION

1. Schedule of Meetings

1.	September 18/89	Inaugural/Organizational
2.	October 31/89	Staff Briefing - Manitoba Health Services Commission/ Manitoba Health/J.A. Hildes Northern Medical Unit
3.	November 1/89	Mr. Larry McCafferty, Regional Director, Medical Services Branch
4.	November 28/89	Trip to Pine Falls
5.	November 29/89	Trip to Hodgson

(Note: January/February - letters out to all towns, community councils, and 61 Band Councils asking for input to Task Force)

6.	February 5/90	Trip to The Pas
7.	February 6/90	Trip to Thompson
8.	March 27/90	Trip to Flin Flon
9.	May 8/90	Trip to Brochet
10.	May 9/90	Trip to Norway House
11.	June 18/90	Trip to Churchill

IV OVERVIEW

1. Health Status of Northern & Native Residents

1.1 Population

A distinctive feature of the population of northern Manitoba rests in its age distribution. The northern population is also heavily comprised of Native people. The population pyramid is therefore very broadly based. (Figure 1) With a birth rate approximately two times higher than the population as a whole, the base of the pyramid is being significantly replenished. The definition of population is not without difficulty in this case. Treaty status Indians are identifiable by an A code on Manitoba Health Services Commission's files. Non-status Indians and Metis people, many of which live in similar conditions to treaty status people are more difficult to identify. Commonly used estimates of non-treaty Native people range from equal to twice the number of treaty status people. There are 63,484 treaty status Indians in Manitoba (January 1989). The population of northern Manitoba (Thompson/Norman) was 72,661. These issues have been further complicated by Bill C-31 allowing for reinstatement of Indian women who had married non-treaty status males. It is estimated that this will add an estimated 11,000 status Indians to the total in Manitoba.

1.2 Mortality

Heavily influenced by the Native component of the population, death rates in all age groups exceed that of the population as a whole (by average of 2.6 times). Infant mortality, largely in the post-neonatal age group is twice provincial averages. Death by injury and suicide are particularly high in the adolescent and young adult age group. Indians had three times the age adjusted potential years of life lost (PYLL) and a six year gap exists in life expectancy at birth for treaty status Manitobans. Alcohol contributed to 16% of all Indian deaths in 1988. Injury and poisonings are in fact the leading cause of death in Manitoba Indians for ages 1 - 44 years, when it drops to the second leading cause of death.

1.3 Morbidity

Morbidity of residents of northern Manitoba is once again heavily dominated by the Native population. Mortality, as a reflection of the extreme of outcomes will predict areas of excess morbidity. In Manitoba, morbidity across diagnosis codes, as measured by hospital utilization (per 1000 population), show that northern non-status residents approximate provincial rates in most diagnostic categories and exceed provincial rates for disease of the respiratory tract, mental disorders, disease of the digestive system, pregnancy,

and perinatal difficulties. When status Indians are included, northern rates are excessive for infectious and parasitic diseases, endocrine diseases, diseases of blood, disease of the respiratory tract, disease of the digestive system, pregnancy, skin disease, congenital anomalies, perinatal conditions, injury and poisoning (Table I). Indeed, the excesses experienced by the northern non-treaty status population are likely contributed significantly to by non-status Native populations.

The Vital Statistics Report, 1988, of Medical Services Branch, provides valuable insight into specific health problems.

Although the incidence of tuberculosis in Manitoba Indians has decreased dramatically in the last decade, it remains eight times that of non-Indians.

Diabetes has achieved epidemic levels in the Native community with a discrete patient rate greater than two times that of non-Indians for 15-64 age group.

Aboriginal communities express concern regarding mental health of their community members. Although hospital utilization rates for mental disorders of status Indians are less than total Manitoba rates, it is likely that this is influenced by the availability of services. (Table I) The First Nations

Confederacy Report on Mental Health (1988) suggests a high incidence of anxiety disorders, alcohol and drug abuse, suicide and parasuicide in this community.

It is not the intent of this report to extensively catalogue the extent of ill health amongst the Native population. The data supporting the health needs are widespread and are only touched upon here. There is a considerable discrepancy between the health of Natives and northerners, and between Natives and the province as a whole. The health of non-Native northerners approximates that of the province as a whole.

1.4 Utilization

Per capita, Manitoba Health Services Commission physician expenditures is somewhat less for northern Manitoba than for Manitoba as a whole. (Table II) Additional resources are provided to status Indian populations by Medical Services Branch of Health & Welfare Canada (Tables III & IV).

The use of hospital facilities by northern patients suggests an intermediate level for Norman and Thompson compared to other regions in the province with Westman, Parklands, and Central regions all providing higher in-patient hospital days per 1000 population. (Figure 2) Thompson region has the same active treatment bed rate per 1000 as Manitoba as a whole,

while Norman has an active treatment bed rate of 7.7/1000 compared to 4.9/1000 for the province as a whole. (Table V)

If we examine hospitalizations of northerners we see 26% of acute care hospitalizations of Norman status Indians and 23% of other Norman residents actually occur in Winnipeg. Forty-four percent of treaty status residents of Thompson region and 33% of Thompson non-treaty residents' hospitalizations occur in Winnipeg. (Table VI)

Manitoba Health Services Commission hospital expenditures in northern Manitoba are noted in Table VII. The nursing station expenditures listed include insurable medical services performed within the station. Medical Services Branch also expended ~~65~~ 85 million dollars in support of uninsured services within Manitoba. (Table ~~XVI~~ III).

Personal care home facilities in northern Manitoba include Flin Flon Personal Care Home, Northern Lights Manor, Flin Flon St. Paul's Residence (The Pas) and Pinaow-Wachi (Norway House), for total rated personal care bed capacity of 156 beds. Bed rates/1000 population are well below that of the province. (Table V) There are no extended care facilities in northern Manitoba.

2. Health Services Organization

2.1 Background

The provision of health services and the legislated mandate thereof remains in some dispute. The BNA Act (1867) incorporated Indians and Indian lands as a federal responsibility. This was maintained in the Constitution (1982). The main outcome of this mandate has been the Indian Act (1874). This Act deals mainly with the management of land, resources and Band affairs. The Act does give the federal government power to "prevent, instigate, and control spread of disease on reserves.....provide medical treatment and health services for Indians (Section 73) and to allow Bands to make health related bylaws (Section 81)".

Treaty #6 (1876) suggests other responsibilities including "medical chest kept at the house of the Indian agent for the use of Indians...". The federal government has not accepted responsibility for the provision of services as a treaty right, however.

Likewise, the primary jurisdiction over health was given as a provincial responsibility by the BNA and the Constitution. The universality criterion of Health Insurance Diagnostic Services Act, Medicare Act and the more recent Canada Health Act define a provincial responsibility for the health through

insured services of Native people. The apparent conflict between these Acts remains unresolved.

2.2 Medical Services Branch

Medical Services Branch was established in 1962 to support the uninsured service needs of treaty status peoples.

In 1979 the federal government developed the Three Pillars of existent Indian Health Policy.

'The socioeconomic, cultural, and spiritual development of Indian communities'

'The traditional relationship of the Indian people to the federal government'

'The Canadian Health System where federal, provincial and local governments all have a role to play'.

In 1988, the federal government launched a health program transfer initiative which in 1989 received the following Treasury Board approval.

FEDERAL PRINCIPLES TO ENABLE TRANSFER OF CONTROL

THE PRINCIPLES APPROVED BY TREASURY BOARD REQUIRE A TRANSFER PROCESS WHICH WILL:

1. OPERATE WITHIN CURRENT LEGISLATION;

2. BE OPTIONAL AND AVAILABLE TO INDIAN COMMUNITIES WITHIN PROVINCIAL BOUNDARIES;

3. PERMIT HEALTH PROGRAM CONTROL TO BE TAKEN ON AT A PACE DETERMINED BY COMMUNITY NEEDS, INTEREST AND MANAGEMENT CAPACITY;

4. INCLUDE THE FOLLOWING RESOURCES FOR PROGRAMS CURRENTLY DELIVERED BY HEALTH AND WELFARE;

- COMMUNITY HEALTH SERVICES
- NATIONAL NATIVE ALCOHOL AND DRUG ABUSE PROGRAM
- DENTAL SERVICES (PROFESSIONALS UNDER CONTRACT OR CONTRIBUTION OR DIRECTLY EMPLOYED BY MSB)
- ENVIRONMENTAL HEALTH AND SURVEILLANCE
- HOSPITAL SERVICES

NON-INSURED HEALTH BENEFITS (NIHB) ARE EXCLUDED EXCEPT PROFESSIONAL HEALTH SERVICES WHICH COMMUNITIES CURRENTLY

RECEIVE THROUGH CONTRACTS, AND/OR CONTRIBUTION AGREEMENTS;

5. INCLUDE ONLY EXISTING PROGRAM RESOURCES IN MEDICAL SERVICES BRANCH. THERE WILL BE NO PROGRAM ENRICHMENT;

6. ENABLE COMMUNITIES TO DESIGN HEALTH PROGRAMS TO MEET THEIR NEEDS AND TO ALLOCATE FUNDS ACCORDING TO COMMUNITY HEALTH PRIORITIES, PROVIDED MANDATORY PROGRAM REQUIREMENTS ARE MET, AND CAPITAL FUNDS ARE USED FOR CAPITAL PURPOSES ONLY;

7. PROVIDED RESOURCES FOR ONGOING HEALTH MANAGEMENT STRUCTURES AT THE COMMUNITY LEVEL TO COMPLEMENT THE CURRENT BAND STRUCTURE FUNDED BY INAC.

8. PERMIT MULTI-YEAR AGREEMENTS (NOT EXCEEDING FIVE YEARS) SUBJECT TO ANNUAL APPROPRIATIONS, WITH DEFINED METHODS FOR ANNUAL PRICE AND VOLUME ADJUSTMENTS;

9. ALLOW COMMUNITIES TO RETAIN UNSPENT BALANCES, AND PLACE ON COMMUNITIES THE RESPONSIBILITY TO ELIMINATE DEFICITS;

10. TRANSFER TO COMMUNITIES ALL MOVEABLE CAPITAL ASSETS ASSOCIATED WITH OPERATING THE HEALTH SERVICES INCLUDED IN THE TRANSFER ARRANGEMENT;

11. REQUIRE ANNUAL EXPANDED AUDITS, AND SCHEDULE EVALUATION OF THE TRANSFER PROCESS AT SPECIFIED INTERVALS;

12. IMPLEMENT NEW FINANCIAL AND PROGRAM MECHANISMS TO DISCHARGE THE ACCOUNTABILITY OF CHIEFS AND COUNCILS TO THE COMMUNITY. CHIEFS AND COUNCILS TO THE MINISTER OF NHW AND THE MINISTER OF NHW TO PARLIAMENT FOR RESPONSIBLE FINANCIAL MANAGEMENT AND OVERALL PROGRAM RESULTS.

13. PROVIDE A MECHANISM FOR INTERVENTION IN THE EVENT OF A HEALTH EMERGENCY OF INABILITY OF A COMMUNITY TO MEET ITS FINANCIAL OR HEALTH PROGRAM COMMITMENTS.

Medical Services Branch, Manitoba Region has a Regional Office in Winnipeg and two Zone Offices (North - Thompson and South - Winnipeg). There are federally run hospitals at Hodgson and Norway House. Nursing stations provide health care to most northern Native communities. Programs are offered which include:

- Maternal/Child Health
- Preschool Health
- Adult Health
- Chronic Disease Registries
- Communicable Disease Control
- Environmental Health Surveillance
- Health Education
- Nutrition
- Outpatient Care
- Special Outpatient Clinics, i.e. Diabetes, Hypertension
- Inpatient Care (largely holding beds in nursing stations)
- Referral Services
- Dental Therapy
- Dentistry
- Hospital Care (Hodgson, Norway House)
- Social Services
- Hospital Visitors
- Interpreter Services
- Native Alcohol & Drug Abuse Program
- Community Health Representative Program
- Physician Services
- Physiotherapy
- Tuberculosis Surveillance

2.3 Provincial Programs

The provincial government provides services to northern patients from two delivery systems:

- Manitoba Health Services Commission funds insured services including hospital care and physician services. Such insured services cover both treaty status and other residents throughout Manitoba.

- Manitoba Health provides services such as public health and home care on a regional basis. Norman (based in The Pas), and Thompson Regions combined have a population of 72,661. Of these, 20,730 are status Indians.

Norman communities (nine) receive a broad variety of provincial services including:

- Northern Health Care (Nursing Stations)
- Public Health
- Medical Officer of Health
- Mental Health
- Continuing Care
- Audiology
- Health Promotion (Diabetes, Nutrition, Smoking, School Health)

Regional services are also provided through Child and Family Services.

Thompson regional communities likewise receive a broad array of services that include:

- Community Health Nursing
  - . Adolescent Health Education Centre
  - . Native Child & Maternal Health Program
- Northern Health (Nursing Stations)
- Medical Officer of Health
- Nutrition
- Audiology
- Continuing Care
- Mental Health
- Dietitian

These services are not provided to treaty status individuals who reside on reserves. They are interpreted by the province as being a federal responsibility. Medical Services Branch, Health and Welfare Canada provides the on-reserve health care services.

2.4 1964 Agreement

In 1964 Medical Services Branch and Manitoba Health undertook an Agreement, without consultation with communities, to transfer administrative responsibilities to minimize duplication of services by designating which government would provide services. (Appendix 1)

Moose Lake, Grand Rapids, Cedar Lake, Cormorant, Wabowden, Sipavisk, Thicket Portage, Pikwitonei, Ilford, Gillam, and Bird are thus a responsibility of the provincial government.

Nelson House, Pukatawagon, South Indian Lake, Brochet, Split Lake, York Landing, Shamattawa, The Pas Reserve, Norway House, Cross Lake, St. Therese Point, and Granville Lake are the responsibility of the federal government.

This Agreement has been recently complicated by Bill C-31 where many residents previously defined as non-status are now designated as status Indians.

More importantly, the Agreement is increasingly seen as an obstacle in the negotiation of transfer of control for communities now designated as provincial responsibilities.

There are extensive services provided by both levels of government in this province. Although the 1964 Agreement has likely prevented duplicative (and redundant) services, there has been almost no meaningful coordination between the two governments in the provision of services to Manitoba's aboriginal population.

One frequently cited example lays in the area of mental health where the province will not provide services "on reserve" and the federal government with some exceptions has insisted that mental health to treaty status aboriginal people is a provincial concern.

Another alarming example has been the lack of involvement and perhaps even awareness of the province in the discussion and planning of the transfer of control process.

This lack of communication and the ongoing frequently described jurisdictional disputes between governments has not served the people of northern Manitoba well.

Hospitals are governed by hospital boards which are incorporated individually or under the District Health Services Act. Board representation is commonly a mixture of designated seats (i.e. municipality and board appointed seats).

2.5 Northern Patient Transportation Program

As previously noted a significant number of hospitalizations of northern residents actually occur in Winnipeg. Likewise, large numbers of medical referrals of patients occur both within and outside of respected regions. There has been a gradual increase in referrals to Winnipeg from 1986-89. (Figure 3) All evacuation costs, elective and emergent, for treaty Indians is borne by Medical Services Branch.

Northern Patient Transportation Program is a Manitoba Health Services Commission funded program. Funds are allocated to designated hospital committees for allocation in support of elective referrals and followup visits. The mode of transportation varies and is determined on a case-by-case basis by the local committee. The NPTP budget was $2.7 million in 1990-91, providing 13,599 transports from northern Manitoba.

Air Ambulance Services are available in nearly all communities in Manitoba. The program, equipment and staff are all based in Winnipeg. Other northern alternatives have been reviewed. In terms of cost and in terms of availability of tertiary care specialists, it has been determined that Winnipeg is the most effective of bases available from northern Manitoba and

approximately 1.7 million (of 2.7 million budget) is spent serving northern Manitoba.

2.6 Churchill

The Churchill Health Centre, in Churchill, Manitoba, has served a unique role as the "base" hospital for secondary care of Inuit people residing in the Keewatin District of the Northwest Territories. Churchill Health Centre was opened in 1976 and once served a town and population many times larger than that which it now locally serves. As the local population has decreased, the proportionate contribution of Inuit from the NWT to bed utilization and ambulatory services has climbed dramatically.

The Churchill Health Centre has functioned as a unique model with broadly based services in public health, social services, family supports, alcohol treatment, probation, child welfare, and dentistry, besides a medical clinic and inpatient facility. The physicians have been provided to Churchill Health Centre for 20 years by the J.A. Hildes Northern Medical Unit, who also provides itinerant services in the Keewatin District. A single doctor, also provided through the J.A. Hildes Northern Medical Unit, is based in Rankin Inlet, NWT.

There has been increasing interest within the NWT on providing services within the NWT. This has been fostered by the natural tendencies that comes with increasing autonomy and has been exacerbated by concerns relating to future entitlement of Inuit who have been born outside the Territories.

Should there be any major re-direction of Keewatin patients away from the Churchill Health Centre, it is clear that the present facility would be redundant and its configuration and function would have to be changed to suit the needs of the local population of the Churchill Health Centre.

V RECOMMENDATIONS

1. Overview

No consideration of health in northern Manitoba can be made without consideration of the social, economic and environmental overlays upon the population. Housing, although improving over the last decade, remains inadequate for the needs of northern Manitoba. Multi-family occupation of housing is not uncommon and provides a degree of crowding, well known to exacerbate and cause illness.

Running water and sewage serves a minority of Manitoba's northerners outside of the larger centres. The relationship between health, illness and potable water and waste disposal have been well known for several hundred years. We have lacked the political and local commitment to act upon that knowledge.

Unemployment and poverty are all too frequent visitors to our northern citizens. The alienation and stress of poverty is the most singular common denominator of illness that we ignore as recognition that we have very far to go in achieving for all children what we would achieve for our own.

All of these situations must be recognized as **UNACCEPTABLE**. We must work towards change. It is only by recognizing health in its broadest context that we are able to seek the fullest solutions.

RECOMMENDATION #1

IMPROVEMENTS IN HEALTH AND RELATED SERVICES TO NORTHERN MANITOBANS MUST BE A MULTISECTORAL RESPONSIBILITY. COORDINATION IN PLANNING AND SERVICE DELIVERY, AND RESOURCE ALLOCATION IS ESSENTIAL ACROSS THE MANY DEPARTMENTS, AGENCIES AND GOVERNMENTS INVOLVED.

Finally, a comprehensive and accessible health system cannot be seen as having achieved its potential value if equity has not been achieved in services and health of the citizens of the province.

It is in the area of **EQUITY** that we face our greatest challenge.

If we are to have any impact on future improvements in health, the concept of **EMPOWERMENT** is an essential one.

Those populations suffering ill health must become primary stakeholders in the system that serves them.

This indeed is a basic tenet of the health promotion movement now having such a visible presence in our communities. The Task Force observed an existing model of health promotion in MOKAKIT. (Appendix 2)

RECOMMENDATION #2

THAT THE TRANSFER OF CONTROL PROCESS IS IMPORTANT FOR ABORIGINAL PEOPLE AND SHOULD BE SUPPORTED FOR THOSE BANDS WHICH UNDERTAKE IT.

2. Means to Improve Recruitment & Retention

2.1 Physicians

There has been a considerable increase (4%) in the number of physicians added to the province over the last decade. There is considerable variation across the province in ratio of population per physician. Norman has a physician/population ratio of 1/835. The provincial ratio is 1/555. Approximately 50% of rural practising physicians are foreign medical graduates. There were only 19 specialists functioning outside of Winnipeg or Brandon in 1989. Few practice in northern Manitoba.

There are a variety of payment methods in northern Manitoba that include:

1. Fee-for-service
2. Salary

The J.A. Hildes Northern Medical Unit provides one model of comprehensive medical services in northern/remote communities. It employs salaried physicians and provides a broad range of itinerant specialty services. Itinerant consulting services are also extensively provided on sessional or fee-for-service payments in areas in northern Manitoba.

The Manitoba Medical Association/Manitoba Health Services Commission fee schedule recognizes a 10% fee differential for resident physicians billing fee-for-service in northern Manitoba.

The Task Force noted that physician specialists who visit the north are not paid the 10% fee differential. While such itinerant specialists do not incur overhead costs in the north, it was felt that some incentive was appropriate to make specialist services more available in the north rather than moving many patients to Winnipeg. The Task Force felt that the concept of northern allowance should apply to other health professionals as it does to physicians.

RECOMMENDATION #3

THE MANITOBA HEALTH SERVICES COMMISSION EXCLUDE THE NORTHERN ALLOWANCES COMPONENT FROM THE MANITOBA MEDICAL ASSOCIATION AGREEMENT.

RECOMMENDATION #4

THE MANITOBA HEALTH SERVICES COMMISSION RETAIN THE 10% NORTHERN ALLOWANCE FOR PHYSICIANS PRACTICING IN THE NORTH AS WELL AS ADD 0.5% PER YEAR FOR PHYSICIAN SERVICE IN THE NORTH.

RECOMMENDATION #5

THE MANITOBA HEALTH SERVICES COMMISSION PROVIDE HALF OF THE NORTHERN ALLOWANCE (e.g. 5%) FOR ITINERANT SPECIALISTS WHO SERVE NORTHERN RESIDENTS LOCALLY.

RECOMMENDATION #6

NORTHERN ALLOWANCES FOR OTHER NORTHERN HEALTH CARE PROFESSIONALS BE PROVIDED IN A SIMILAR FASHION AS FOR PHYSICIANS (SEE RECOMMENDATION #3).

The Standing Committee on Medical Manpower has an extensive array of programs including:

i) physician placement
ii) locum tenens pool
iii) rural residency
iv) continuing medical education
v) anaesthesia training
vi) family medicine training
- summer students
- clerkship
- residency

vii) family medicine training program in Dauphin

There has been difficulty in attracting rural students to apply to the Faculty of Medicine. Evidence suggests that students from rural areas are more likely to return upon graduation. Likewise, students who train in rural areas are more likely to practice in rural areas according to American research. To that end, the Faculty of Medicine has proposed a rural stream within its fourth year program to enhance the rural exposure of those interested in rural practice.

The Task Force recognized that several factors must be considered for physician recruitment and retention in remote communities. Firstly, each community must play a larger role in the recruitment process. They must "own" the issue to initiate successful activities to recruit a new physician. Secondly, attention is required to the physician's spouse's needs to ensure a good fit with community activities.

RECOMMENDATION #7

THE STANDING COMMITTEE ON MEDICAL MANPOWER BE ENCOURAGED TO DETERMINE THE PROSPECTIVE PHYSICIAN'S SPOUSES' GOALS AND ASPIRATIONS, AND ONCE DETERMINED, MAKE EVERY EFFORT TO ENSURE THAT SUCH CAN BE MET IN THE LOCATION BEING CONSIDERED.

The Special Premedical Studies/Access Program of the University of Manitoba and funded by the province of Manitoba has gone a long way in easing access to health professional training for Native students of Manitoba. To date, it has produced five physicians, 3 dentists, and 1 physiotherapist, within the health professions. All are functioning in support of the needs of the Native community.

In recognizing the gap in health previously described for Manitoba's Native people, it is essential that the pool of Native physicians be further expanded.

RECOMMENDATION #8

SPECIAL PREMEDICAL STUDIES PROGRAM/PROFESSIONAL HEALTH PROGRAM MUST BE SUPPORTED TO FURTHER PRODUCE NATIVE PHYSICIANS TO ENHANCE THE CAPABILITIES OF THE PROVINCE IN PROVIDING CULTURALLY APPROPRIATE CARE TO A GROUP OF CITIZENS IN GREAT NEED.

RECOMMENDATION #9

THE FACULTY OF MEDICINE IMPROVE ITS EFFORTS TO RECRUIT STUDENTS FROM NORTHERN MANITOBA.

RECOMMENDATION #10

BURSARY PROGRAMS FOR NORTHERN STUDENTS BE DEVELOPED SO THAT THEY MAY ATTEND UNIVERSITIES AND COLLEGES WITHOUT ECONOMIC HARDSHIP.

RECOMMENDATION #11

THE GOVERNMENT OF MANITOBA MUST SUPPORT THE RURAL STREAM PROPOSAL OF THE FACULTY OF MEDICINE TO EXPAND THE EXPOSURE OF STUDENTS TO RURAL AND NORTHERN NEEDS.

RECOMMENDATION #12

THE FAMILY MEDICINE TRAINING PROGRAM SHOULD BE IMPLEMENTED IN DAUPHIN. ONCE THE EDUCATIONAL PROCESS CAN BE DOCUMENTED AS EFFECTIVE, THE FAMILY MEDICINE RURAL TRAINING PROGRAM SHOULD BE EXPANDED TO INCLUDE A SITE IN NORTHERN MANITOBA.

RECOMMENDATION #13

THE MANITOBA HEALTH SERVICES COMMISSION SHOULD CONTINUE TO DEVELOP ALTERNATE FUNDING SCHEMES AND INCENTIVES TO ATTRACT PHYSICIANS TO NORTHERN MANITOBA.

As previously noted, there is a large number of patient transports from northern Manitoba undertaken for elective and emergent physician and hospital care in Winnipeg. The Task Force noted that 3 or 4 pediatricians could practice full time and reside in the north. Currently, none do so.

RECOMMENDATION #14

REFERRAL PATTERNS/MIX AND ACUITY BE EXAMINED BY CENTRE FOR HEALTH POLICY & EVALUATION, UNIVERSITY OF MANITOBA. IN THOSE AREAS WHERE SERVICE PROVISION IN THE NORTH APPROXIMATES COSTS OF TRANSPORT, SPECIALTY SERVICES AND REQUIRED SPECIALISTS SHOULD BE TARGETED FOR SPECIAL RECRUITMENT EFFORTS.

RECOMMENDATION #15

FOR THOSE SERVICES THAT CANNOT BE MADE AVAILABLE IN NORTHERN MANITOBA, A COMPREHENSIVE ITINERANT SPECIALIST PROGRAM SHOULD BE DEVELOPED CONSISTENT WITH SPECIFIC NEEDS OF NORTHERN MANITOBA AND ITS FACILITIES.

2.2 Nurses

Nurses play an essential role in the delivery of services to northerners in Manitoba. In addition to hospital based and public health roles, nurses serve in nursing stations as primary care givers and as liaison between communities and the larger health care system. There are increased stresses attached to all types of northern nursing practice including acuity of illness in the population, cross cultural and language barriers, isolation, and level of remuneration. As a consequence of these stresses, high nursing turnover has been a perpetual problem for northern facilities and nursing stations.

Keewatin Community College has developed innovative programs for Licensed Practical Nurses and stepwise diploma training. More recently, Swampy Cree Tribal Council and the University of Manitoba have mounted a Baccalaureate Program in The Pas.

All of these programs have or will fill northern needs. Several hundreds of nurses have now been trained at LPN and RN levels. The majority of graduates stay in northern Manitoba.

There is some concern that if nursing requires Bachelor level training for entry to nursing practice there will be considerable stress placed on northern facilities, clinics and nursing stations.

RECOMMENDATION #16

NORTHERN NURSING PROGRAMS FOR TRAINING NURSES FOR THE NORTH AND IN THE NORTH BE MAINTAINED OR EXPANDED.

RECOMMENDATION #17

MANITOBA HEALTH BE ASKED TO DO AN ANALYSIS OF THE SPECIFIC IMPACT IN THE NORTH FOR ENTRY TO PRACTICE AT A BACCALAUREATE LEVEL.

Northern nursing roles include nursing station functions where nurses provide a broad range of professional services including public/community health, emergency services and primary care. The nursing roles in primary care (often referred to as nurse-practitioner roles) have not been well

defined. Recently MARN has developed a proposal to define and recognize these roles.

RECOMMENDATION #18

NURSES DO PROVIDE PRIMARY AND EMERGENCY CARE IN MANY REMOTE COMMUNITIES IN MANITOBA'S NORTH. THEY SHOULD BE RECOGNIZED FOR THESE FUNCTIONS.

There are few educational programs, however, that allow for the development and maintenance of competence relevant to the role of nurse-practitioner. Those programs that do exist prepare only a small fraction of nurses working in northern nursing stations. The Baccalaureate Program (Swampy Cree Tribal Council/University of Manitoba) does have several modules relevant to these roles.

RECOMMENDATION #19

ONCE RECOGNITION AND DEFINITION OF THE NURSE PRACTITIONER ROLE (MANITOBA ASSOCIATION OF REGISTERED NURSES) HAS BEEN DEVELOPED AND ACCEPTED, TRAINING AND MAINTENANCE OF COMPETENCE PROGRAMS MUST FOLLOW. THE CLINICAL NURSE TRAINING PROGRAM SHOULD BE A HIGH PRIORITY TO ENSURE THE PRESENCE OF CLINICALLY WELL TRAINED NURSES IN NURSING STATIONS.

THIS PROGRAM SHOULD BE MADE AVAILABLE THROUGH EXISTENT EDUCATIONAL INSTITUTION OR INSTITUTIONS, AND SHOULD BE JOINTLY FUNDED BY BOTH LEVELS OF GOVERNMENT.

There are also stresses placed on nurses working within northern facilities. High turnover remains a substantial problem often leading to difficulties in morale. There are frequent lapses in coverage, especially of specialty trained nurses in the intensive care nursing specialties. Considerable concern was expressed that despite these difficulties, efforts to improve nursing recruitment and retention were inconsistent.

RECOMMENDATION #20

MANITOBA HEALTH SERVICES COMMISSION NEGOTIATE WITH NORTHERN HOSPITALS TO ENSURE ADEQUATE RECRUITMENT AND RETENTION OF NURSES. REMUNERATION, HOUSING, AND CONTINUING EDUCATION MUST ALL BE CONSIDERED TO ENSURE COMPETENT AND CONSISTENT NURSING COVERAGE. THE SPECIAL STRESSES AND DIFFICULTIES OF RECRUITING TO NORTHERN MANITOBA MUST BE RECOGNIZED IN THESE NEGOTIATIONS.

2.3 Other Health Professionals

There are a great many other individuals and professional groups that make up the team of workers caring for the needs of northern Manitoba. Unfortunately, the provision of these services has proven difficult.

Services that are provided tend to be the result of individual initiative and historical developments rather than a systematic assessment of need matched to services.

Areas of particular concern include dentistry, dental hygiene, audiology, speech and language therapy, physiotherapy, and occupational therapy.

Like many of the medical specialties, access to these professionals often necessitates travel to Winnipeg and at times very extended waiting periods.

RECOMMENDATION #21

MANITOBA HEALTH SERVICES COMMISSION AS PART OF ITS PROGRAM PLANNING PROCESS MUST PROVIDE COMPREHENSIVE AVAILABILITY OF HEALTH PROFESSIONALS IN NORTHERN AREAS. IF SERVICES CAN BE VOLUME JUSTIFIED IN INDIVIDUAL INSTITUTIONS, TARGETED RECRUITMENT

SHOULD BE ALLOWED. IF VOLUME CANNOT JUSTIFY FULL-TIME PARTICIPATION, ITINERANT SERVICES SHOULD BE FORMALLY AND SYSTEMATICALLY PROVIDED. THESE SERVICES SHOULD BE FUNDED THROUGH FACILITY BUDGETS.

RECOMMENDATION #22

ALL PROFESSIONAL FACULTIES MUST BE MORE AWARE OF THE NEEDS OF NORTHERN MANITOBA AND MAKE EFFORTS TO ENCOURAGE APPLICATION OF NORTHERN STUDENTS TO THEIR PROGRAMS.

There are some communities that are so small as to receive primary and preventive care from community health workers and community health representatives with "satellite" coverage by nurses. These individuals function admirably in often very stressful situations.

There was considerable concern expressed regarding the ethics and equity of such service provision in remote communities. It is difficult to justify this type of service provision in remote areas.

RECOMMENDATION #23

COMMUNITY HEALTH WORKERS IN REMOTE COMMUNITIES BE PROVIDED WITH OPPORTUNITIES FOR CONTINUING EDUCATION AND BE PROVIDED WITH INCREASED SUPPORT OF ITINERANT NURSES.

Finally, concerns relating to the mental health needs of northern Manitoba were frequently visited upon the Committee. Needs can be clearly defined for both aboriginal and non-aboriginal communities.

RECOMMENDATION #24

THE NEED FOR MENTAL HEALTH PROFESSIONALS IN THE NORTH IS ACKNOWLEDGED AND LIKE OTHER MEDICAL/NURSING SPECIALTIES, TARGETED EFFORTS SHOULD BE DEVELOPED.

There was a strong feeling, however that despite the contribution of health professionals, the needs in mental health were community-based, and the solutions resided likewise in the community. Community input to the training program of community mental health workers was seen as vital to ensure that services were appropriate and acceptable.

RECOMMENDATION #25

THE COMMUNITY MENTAL HEALTH PROGRAM BE EXPANDED SO AS TO PROVIDE A MORE COMPREHENSIVE SERVICE IN NORTHERN COMMUNITIES. THE TRAINING OF COMMUNITY MENTAL HEALTH WORKERS SHOULD BE SEEN AS A PROVINCIAL RESPONSIBILITY.

3. Means to Improve Health Service Organization

It is clear that the degree of communication and consultation between the federal and provincial governments has been far from adequate. It is also clear that aboriginal people as recipients of services from both governments have been caught in the middle, almost always to their disadvantage.

RECOMMENDATION #26

A STANDING TRIPARTITE COMMITTEE IN HEALTH BE ESTABLISHED INCLUDING THE PROVINCE, FEDERAL GOVERNMENT AND REPRESENTATIVES OF ABORIGINAL PEOPLES. THIS COMMITTEE SHOULD BE FORMALLY STRUCK WITH THE TASK OF IMPROVING COORDINATION AND COMMUNICATION.

This is not intended to undermine any of the bilateral relationships, formal or informal, between any of the involved parties.

The 1964 Agreement is now seen as disadvantageous by the people it was designed to serve. It is also noteworthy that they were not involved in its undertaking.

RECOMMENDATION #27

THE 1964 AGREEMENT SHOULD BE RESCINDED BY BOTH LEVELS OF GOVERNMENT AND ALTERNATIVE ARRANGEMENTS EXPLORED THROUGH THE PROPOSED TRIPARTITE COMMITTEE.

A pervasive, remarkable feature of any review of northern health needs is the high utilization of services by aboriginal people, usually far in excess of a proportionate contribution by population. Many northern facilities have bed utilization by aboriginal peoples at 60-80% of the total. Likewise in many communities and districts aboriginal people do make up a large proportion of the population.

There are a number of striking consistencies that must be seen as unacceptable within our health care system:

3.1 Board Representation

Despite large proportionate population contributions to their catchment, most hospital boards have no or few aboriginal board members. If compared to the actual bed utilization this issue is even more concerning.

This can no longer be seen as acceptable. It is only through involvement, and through empowerment that issues of equity can be addressed.

RECOMMENDATION #28

THE PROVINCE OF MANITOBA AMEND THE DISTRICT HEALTH & SOCIAL SERVICES ACT AND ALL HOSPITAL ACTS TO LEGISLATE PROPORTIONATE BOARD REPRESENTATION BY ABORIGINAL PEOPLE ON HOSPITAL BOARDS. IN THOSE AREAS WHERE BED UTILIZATION BY ABORIGINAL PEOPLE IS DISPROPORTIONATELY IN EXCESS, ADDITIONAL BOARD SEATS FOR ABORIGINAL PEOPLE SHOULD BE PROVIDED.

This will truly serve to allow aboriginal people to work as partners in the improvement of services to northern Manitoba. A necessary prerequisite is agreement from Medical Services Branch, Health and Welfare Canada to assume any share of

disallowed hospital board costs as for any municipal board representative on the hospital board.

3.2 Employment

Hospitals serve as important economic bases within communities. An important part of the economic base relates to employment. The employment of aboriginal people is essential to their own economic development and to the communities they serve. Aboriginal people are under-represented in the workforce of many northern institutions.

RECOMMENDATION #29

THE MANITOBA HEALTH SERVICES COMMISSION ENCOURAGE FACILITIES TO DEVELOP EMPLOYMENT TARGETS FOR QUALIFIED ABORIGINAL PEOPLE ACROSS THE BREADTH OF THE WORKFORCE. THE ATTAINMENT OF THESE TARGETS SHOULD BE VERY CLOSELY MONITORED.

3.3 Healers

Aboriginal views of health and illness are profoundly different from western views. The view of health stems from a more holistic view of the interaction between people and their environment.

It is not surprising, therefore, that aboriginal healers have many different approaches to health, providing different perspectives of that primary relationship between man and his environment.

These practitioners have worked in parallel with western care givers usually unknown to the "dominant" system. If we are to deal with equity in health in northern Manitoba, aboriginal healers must be available to aboriginal people.

RECOMMENDATION #30

MANITOBA HEALTH SERVICES COMMISSION EXPLORE, THROUGH HOSPITAL BOARDS, MECHANISMS OF ENSURING ACCESS OF THE ABORIGINAL COMMUNITY TO ABORIGINAL HEALERS.

This should be seen as a complementary not conflictive relationship between aboriginal healers and western care givers.

3.4 Native Services

There remain a significant number of aboriginal people who do not have English as a useable language for communication. Despite this interpretive resources are incomplete and

inconsistent. Often other aboriginal staff members, without training, serve as interpreters.

The role of interpreters in the provision of services to aboriginal people has been well recognized. Interpreters serve as more than conduits for communication. They often must serve as c ure brokers between two sometimes disparate cultural conc s. When communication breaks down within the system itse f, they must serve as advocates for aboriginal patients.

RECOMMENDATION #31

THE MANITOBA HEALTH SERVICES COMMISSION SHOULD, CONSISTENT WITH PATIENT LOADS AND THE NEEDS OF THE PATIENTS, FUND LARGE NORTHERN FACILITIES FOR FULL-TIME INTERPRETERS/ADVOCATES. THESE INDIVIDUALS SHOULD HAVE TRAINING IN THEIR ROLE.

The Health Sciences Centre and St. Boniface General Hospital have extensive experience in this area and should be used as resources.

RECOMMENDATION #32

IN SMALLER NORTHERN FACILITIES PERSONNEL SHOULD BE TRAINED AS PART-TIME INTERPRETERS/ADVOCATES, AS A PORTION OF THEIR OVERALL DUTIES.

4. Regionalization

The concept of regionalization in Manitoba has been discussed and reviewed since 1972. The concept in Manitoba has recently been published as a case study. The case study entitled Regionalization and Health Care Policy in Canada: A National Survey and Manitoba Case Study, by L.C. Carrothers, S.M. Macdonald, J.M. Horne, D.G. Fish and M.M. Silver, describes the background within Manitoba and across the country.

Many of the issues facing the health care system in northern Manitoba could be well addressed through regionalization. Issues of human resources might best be dealt with as part of a regional human resources plan.

The allocation of resources, the sharing of technology, the transfer and repatriation of patients from remote areas are all areas that could be well served by regionalization.

Thompson General Hospital has developed an impressive and comprehensive regional plan that must be considered. It already functions extensively as a regional centre.

The history of regionalization suggests, however, that regional plans imposed from the top down invariably meet with considerable resistance and usually fail.

The development of a regionalization process from the bottom up should be seen as a far more viable proposition.

There was considerable interest expressed in the potential for the development of Thompson as a regional centre. There also were many concerns. Some of these related to the ability of the hospital to meet the role expectation at specialty and subspecialty levels.

More importantly, there was considerable hesitation at a community level for fear of losing something.

For a regional plan to be further developed the communities involved must be seen as stakeholders. They must be convinced that it is in their interest to support Thompson as a regional centre.

Previous recommendations regarding board structure, specialty and subspecialty physician/nursing recruitment and retention must be addressed.

RECOMMENDATION #33

THOMPSON SHOULD BE FURTHER DEVELOPED AS A REGIONAL CENTRE PROVIDED STAKEHOLDER COMMUNITIES ARE WILLING TO 'BUY IN'.

RECOMMENDATION #34

THE PAS AND FLIN FLON SHOULD ENTER INTO JOINT PLANNING OF SHARED SERVICES FOR THE NORMAN REGION.

Manitoba Health Services Commission should develop a Regional Planning Committee involving representatives of the communities involved. The concept of regionalization should only be brought to fruition based on negotiations of the involved communities.

5. Transfer of Control

Several Bands have achieved transfer of control and now "control" their health services. Many others are in various stages of negotiation.

Considerable concern remains in the area of funding, liability, capital, expanded programs and uninsured services.

Despite these concerns it is likely that many Bands in Manitoba will achieve transfer in the next three to five years. Many other will choose not to proceed.

The act of transfer will profoundly change the relationship between Bands and the federal government regarding health services. It will also irrevocably increase the involvement of the provincial government. This will occur for several reasons.

i) As the federal role is transferred it is likely that resources of Medical Services Branch will decrease. Although residual responsibilities will likely remain with the federal government, there is a strong likelihood that the resources will not be available to deal with difficulties in the future.

ii) By virtue of their more intense involvement in the health care system, Bands will deal more directly with provincial services (insured and uninsured). This will likewise likely increase interest and expectations of provincial resources. The demand for these resources, recognizing the gap in

services and health presently existent, will be large.

Recognizing the above, it is astounding that the province has remained so uninvolved in the transfer process.

RECOMMENDATION #35

THE DEPARTMENT OF HEALTH/MANITOBA HEALTH SERVICES COMMISSION MEET WITH REPRESENTATIVES OF ABORIGINAL COMMUNITIES TO DEVELOP LIAISON/BEGIN NEGOTIATIONS REGARDING EXPECTATIONS.

RECOMMENDATION #36

THE PROVINCE SHOULD CONSIDER THE POTENTIAL FOR TRANSFER OF CONTROL AS AN UNLOADING OF RESPONSIBILITY/COST FROM THE FEDERAL TO THE PROVINCIAL GOVERNMENT.

The Policy of the Assembly of Chiefs of Manitoba is that health care is a treaty right and that the federal government should not be able to unload their current responsibilities.

RECOMMENDATION #37

THE MANITOBA HEALTH SERVICES COMMISSION SHOULD UNDERTAKE A SENSITIVITY ANALYSIS OF THE FINANCIAL IMPACT OF TRANSFER. THESE FUNDS SHOULD BE CONSIDERED BY THE PROVINCE AS A FUNDING TRANSFER TO THEMSELVES AND UNDERTAKE NEGOTIATIONS WITH THE FEDERAL GOVERNMENT REGARDING POTENTIAL FOR OFFSETTING THIS TRANSFER.

RECOMMENDATION #38

THE PROVINCIAL GOVERNMENT SHOULD SEEK TO BECOME A PARTICIPANT IN FUTURE DISCUSSIONS BETWEEN BANDS AND FEDERAL GOVERNMENT REGARDING TRANSFER. AS THE TRUST RELATIONSHIP IS BETWEEN INDIAN AND FEDERAL GOVERNMENT THIS INVOLVEMENT MAY, BY NECESSITY, BE OBSERVER IN STATUS.

The Churchill Health Centre was discussed earlier as a unique facility providing services to a unique population from outside the province of Manitoba. The provision of these services is essential to the viability of that facility.

The Task Force observed that a small number of northern patients who were awaiting transfer from Winnipeg hospitals experienced delayed discharge of 3 to 4 days. The delay resulted because the patient transfer was by stretcher and the specialized airplane was available only twice per week.

RECOMMENDATION #39

THE MANITOBA HEALTH SERVICES COMMISSION, IN CONJUNCTION WITH MEDICAL SERVICES BRANCH, EXPLORE MEANS FOR THE AIR AMBULANCE TO REPATRIATE STRETCHER PATIENTS FROM WINNIPEG HOSPITALS TO THE NORTH WHEN READY FOR TRANSFER OR DISCHARGE.

RECOMMENDATION #40

THE MANITOBA HEALTH SERVICES COMMISSION NEGOTIATE WITH GOVERNMENT OF THE NORTHWEST TERRITORIES THE POSSIBILITY OF SHARING THE GLOBAL FUNDING OF CHURCHILL HEALTH CENTRE AND IN REALLOCATING BOARD REPRESENTATION ON CHURCHILL HEALTH CENTRE BOARD TO MORE ACCURATELY REFLECT ITS ACTIVITIES.

There remains a considerable problem in determining the health status and the needs of aboriginal people living in urban areas. The few available studies suggest that health status remains similar to that of aboriginal people in rural and northern areas.

Manitoba Health Services Commission data, however, is unable to accurately identify this group.

RECOMMENDATION #41

IT IS ESSENTIAL THAT MANITOBA HEALTH SERVICES COMMISSION UNDERTAKE TO DEVELOP THEIR DATA SYSTEM TO BETTER IDENTIFY AND INCORPORATE THE NEEDS OF URBAN ABORIGINAL PEOPLE.

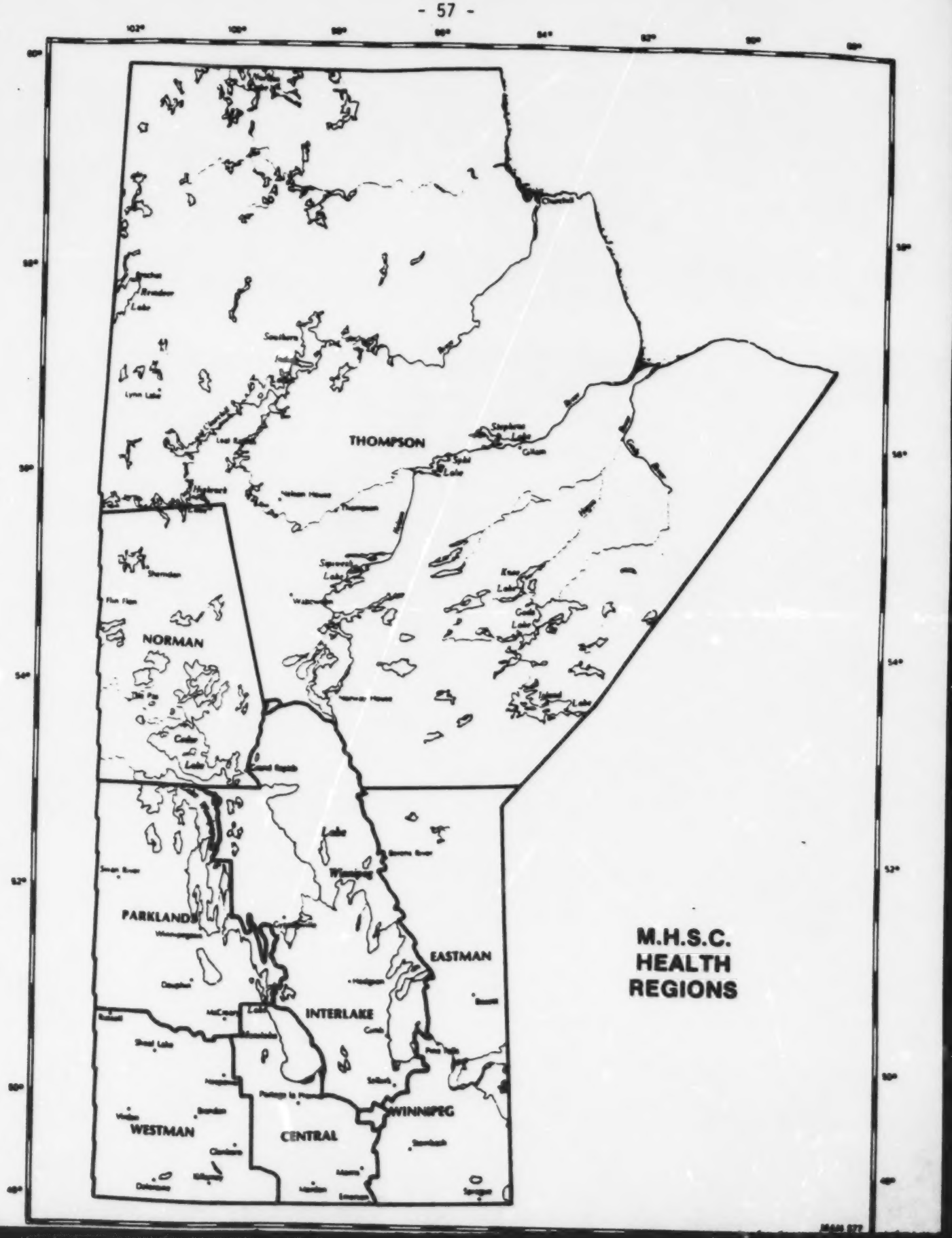
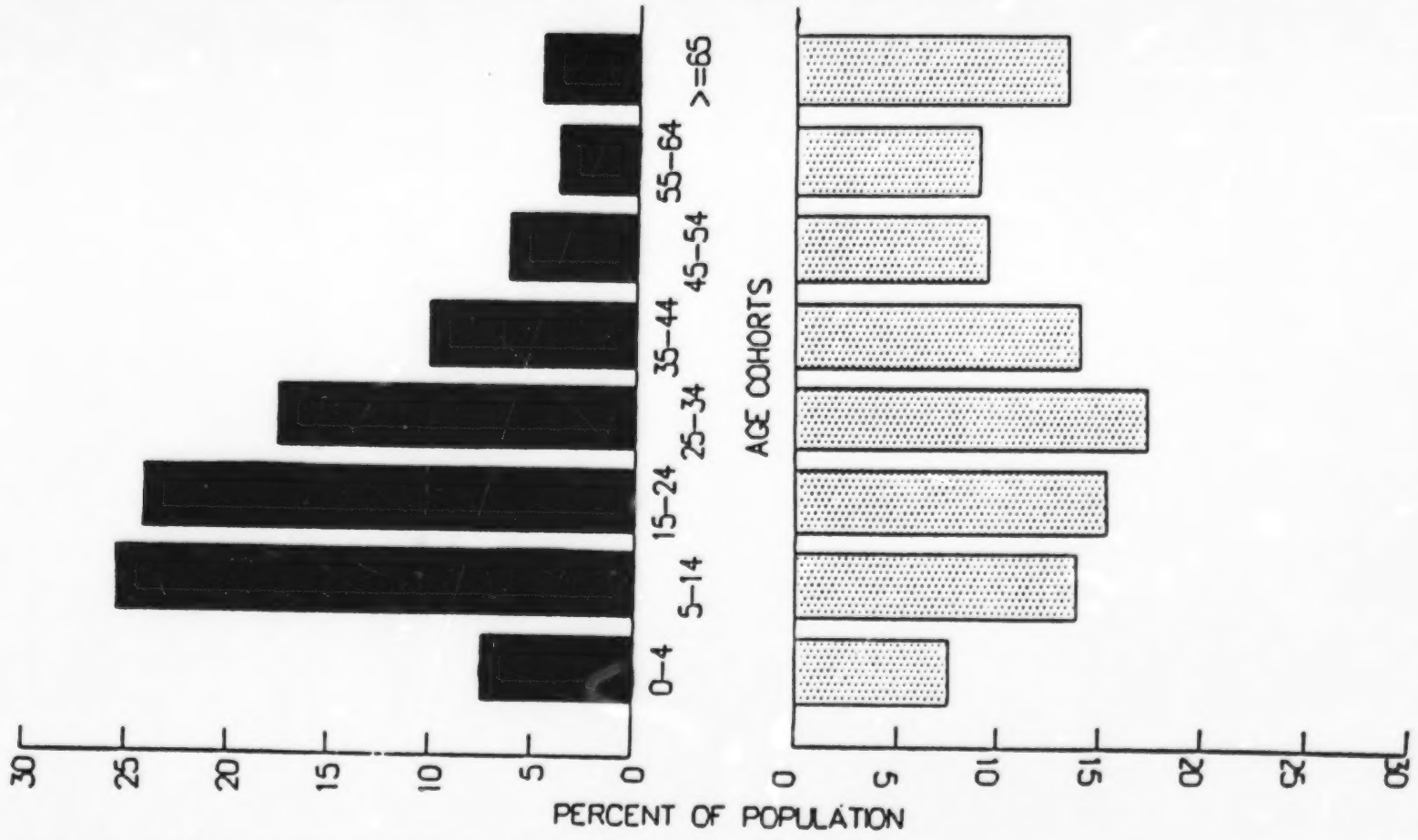

THOMPSON
NORMAN
PARKLANDS
EASTMAN
INTERLAKE
WINNIPEG
CENTRAL
WESTMAN
M.H.S.C.
HEALTH
REGIONS

Figure 1

POPULATION PYRAMIDS

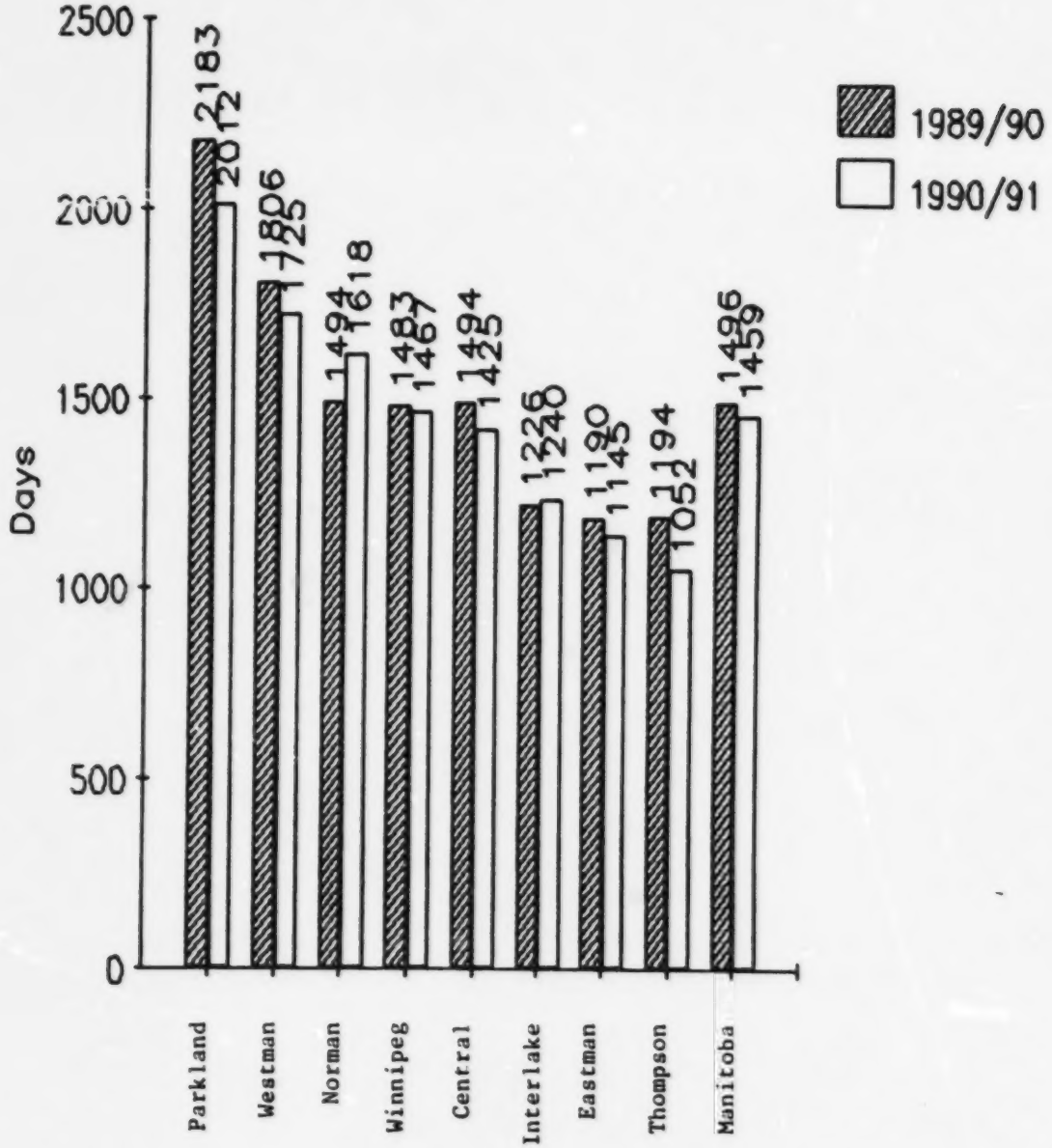
INDIANS AND NON INDIANS 1988



Source: Health & Welfare Vital Statistics, 1988

Figure 2

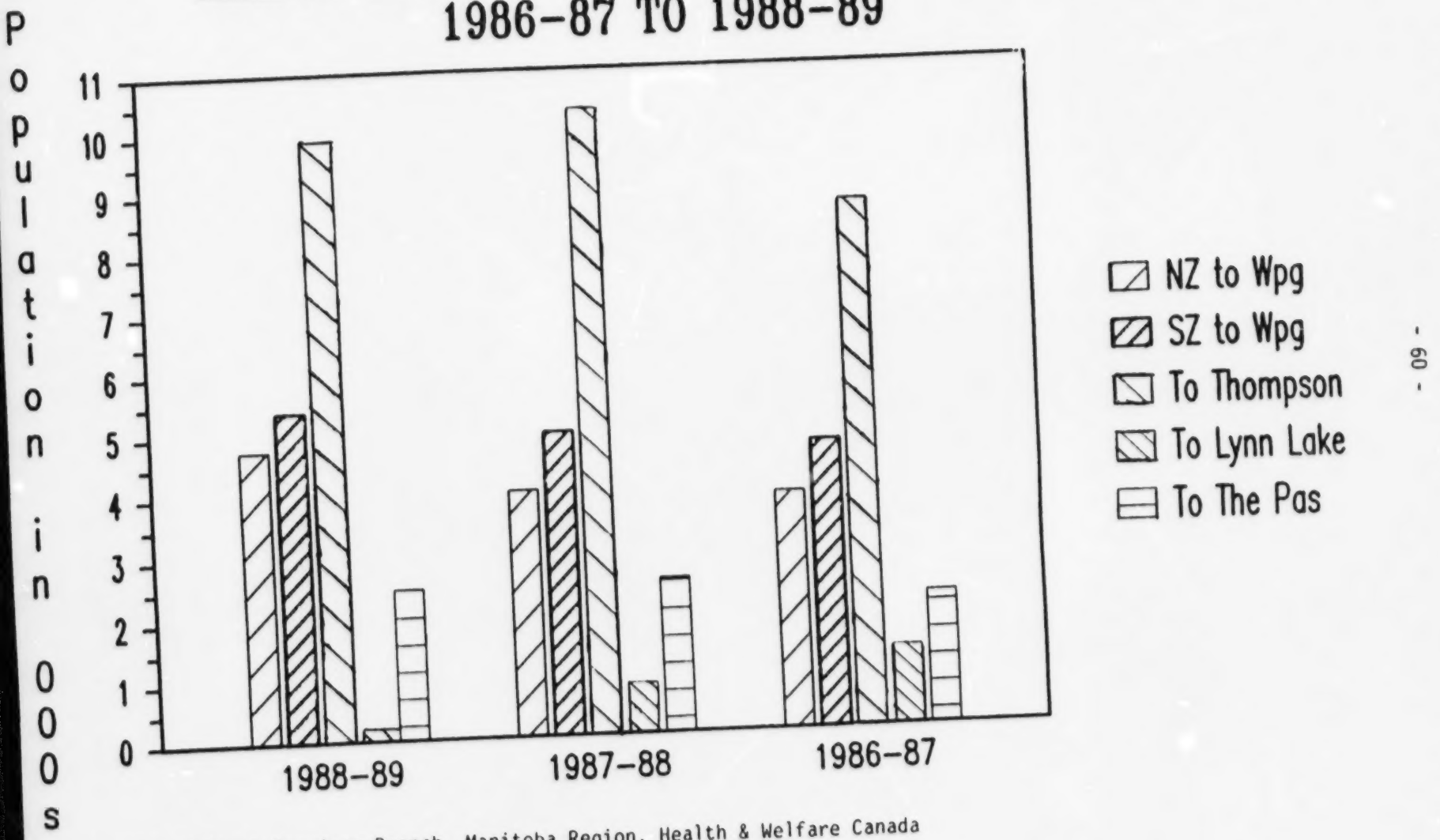
In-Patient Hospital Days per 1,000 Population
by Health Region,
1989/90 and 1990/91.



Source: MHSC Annual Report, 1990/91

Figure 3

MANITOBA EVACUATION PATTERNS
1986-87 TO 1988-89



Source: Medical Services Branch, Manitoba Region, Health & Welfare Canada

Table I

NORTHERN RESIDENTS' SELECTED HOSPITAL UTILIZATION RATES, 1989/90
DAYS PER 1000 POPULATION

Diagnostic Category	Norman Status Indians	Thompson Region Status Indians	Manitoba Status Indians	Norman Residents*	Thompson Region Residents*	All Manitoba Residents
Infectious and Parsitic Diseases	38	39	41	18	9	16
Neoplasms	32	29	38	107	43	150
Endocrine, Nutritional & Metabolic Diseases	40	39	59	34	24	33
Diseases of Blood and Blood Forming Organs	11	14	9	7	2	8
Mental Disorders**	42	119	92	220	39	171
Diseases of the Nervous System and Sense Organs	28	50	74	44	22	100
Diseases of the Circulatory System	167	96	115	151	64	252
Diseases of the Respiratory System	288	240	260	154	96	114
Diseases of the Digestive System	114	134	148	112	171	115
Diseases of the Genitourinary System	81	60	65	86	44	59
Pregnancy, Childbirth & the Puerperium	204	262	229	95	121	80
Diseases of the Skin & Subcutaneous Tissue	54	38	47	22	18	17
Diseases of the Musculoskeletal System	48	42	41	62	28	66
Congenital Anomalies	21	23	21	3	37	6
Conditions Originating in the Perinatal Period	48	10	15	8	2	3
Symptoms, Signs and Ill-Defined Conditions	89	83	96	120	30	50
Injury and Poisoning	179	181	179	130	87	159
Factors Influencing Health Status w/o Diagnosis	80	56	60	111	34	97
Total	1565	1513	1588	1483	871	1496

* Excludes Status Indians, represents all other residents of the region.

** Excludes Hospital Utilization at Selkirk Mental Health Centre, Brandon Mental Health Centre and Eden Mental Health Centre.

Source: MHSC Hospital Table 25, 1989/90.

Table II

Selected Medical Services Utilization, 1989/90
Funded by the Manitoba Health Services Commission
* Fee-for-Service only

	Municipalities	Population	No. of Discrete Patients	Medical Services Expenditures (MHSC only)	Per Capita Medical Expenditures (MHSC only)
Norman Region Status Indians	4	3,240	2,680	$ 579,947	$ 179.00
Norman Region Other Residents	6	21,810	18,733	3,648,476	167.28
Thompson Region Status Indians	20	23,970	19,015	4,062,909	169.50
Thompson Region Other Residents	6	23,641	20,411	3,508,419	148.40
Manitoba Status Indians	61	55,924	48,026	10,532,822	188.34
Manitoba Other Residents	220	1,073,886	931,981	228,904,445	213.16
Manitoba all Residents	281	1,129,810	980,007	$ 239,437,267	$ 211.93

Source: M.H.S.C. Medical Table #A44M778RPT1

* Excludes Northern Health Clinics and the Northern Medical Unit (see Table 2 for details).

Note: Expenditures of Medical Services Branch, Health & Welfare Canada, $71,754,200 during 1989/90, are not reflected in the above figures.

Table III

MEDICAL SERVICES BRANCH
MANITOBA REGION
HEALTH & WELFARE CANADA

1990/91 EXPENDITURES ($000's)

Expenditure	Regional Director and Operations	North Zone	South Zone	Norway House Hospital	P.E. Moore Hospital Hodgson	Total
Salary	$3,588.6	$5,197.6	$5,022.4	$2,224.7	$2,013.7	$18,047.0
Operating:						
Controllable	1,934.3	1,638.3	1,406.5	505.8	484.7	5,930.5
Non-Insured	32,364.2	3,081.0	2,632.8	220.2	137.4	38,435.6
Operating Sub-Total	34,298.5	4,719.3	4,039.3	726.0	622.1	44,366.1
Controllable Contributions:						
Health Services Program	1,611.9	1,912.8	2,273.3	0.0	0.0	5,798.0
NNADAP Program	6,479.4	0.0	0.0	0.0	0.0	6,479.4
NNADAP Capital	0.0	0.0	0.0	0.0	0.0	0.0
Non-Dept. Facilities	2,644.0	0.0	0.0	0.0	0.0	2,644.0
Health Careers	411.9	0.0	0.0	0.0	0.0	411.9
Consultation	96.3	0.0	0.0	0.0	0.0	96.3
Other Contributions:						
Non-Insured Health Services Program	114.0	1,295.9	1,919.3	0.0	0.0	3,329.2
Health Programs Transfer	0.0	1,152.1	607.9	0.0	0.0	1,760.0
Contributions Sub-Total	11,357.5	4,360.8	4,800.5	0.0	0.0	28,518.8
Capital	406.3	744.3	425.6	224.6	267.5	2,068.3
Total	49,650.9	15,022.0	14,287.8	3,175.3	2,903.3	85,000.2

Source: Medical Services Branch
Manitoba Branch
Health & Welfare Canada

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Table IV

Population, Health Facility Beds, and Rates Per 1,000 Population by Health Region, 1990/91.

Health Region	Population(1)	Active Treatment		Extended Treatment		Personal Care Home	
		Number(2)	Rate	Number(2)	Rate	Number(2)	Rate
Central	95,307	412	4.3	50	0.5	751	7.9
Eastman	87,575	212	2.4	20	0.2	453	5.2
Interlake	75,149	213	2.8	-	-	504	6.7
Norman	24,841	192	7.7	-	-	130	5.2
Parklands	47,499	320	6.7	39	0.8	444	9.3
Thompson	48,007	233	4.9	-	-	26	0.5
Westman	117,531	753	6.4	102	0.9	1,505	12.8
Winnipeg	634,936	3,168	5.0 (3)	691	1.1 (3)	4,598	7.2
Manitoba	1,130,845	5,503	4.9	902	0.8	8,411	7.4

(1)M.H.S.C. registered population as of June 1, 1990.

(2)Based on rated capacity as at March 31, 1991.

(3)Active and extended treatment beds for Winnipeg residents, accounting for 80.2% of separated days, were 4.8 per 1,000 population. The remaining beds, accounting for 19.8% of separated days, were used by rural residents and non-residents of the province.

Source: M.H.S.C. Annual Report, 1990/91

Table V

NORTHERN RESIDENTS' SELECTED HOSPITAL UTILIZATION, 1990/91
BY LOCATION OF PATIENT DAYS UTILIZED

Hospitals	Norman Status Indians	Norman Other Residents	Norman Total	Thompson Region Status Indians	Thompson Region Other Residents	Thompson Region Total
Health Sciences Centre	27,794	3,819	31,613	13,357	3,552	16,909
St. Boniface	8,286	1,085	9,371	3,354	1,242	4,596
Misericordia	2,596	725	3,321	1,492	481	1,973
Victoria	676	232	908	238	187	425
Seven Oaks	718	393	1,111	199	135	334
Grace	769	266	1,035	178	316	494
Concordia	274	75	349	136	30	166
Rehabilitation Centre for Children	395	0	395	51	1	52
Winnipeg Hospitals Sub-Total	41,508	6,595	48,103	19,005	5,944	24,949
The Pas Health Complex	3,802	9,638	13,440	452	234	686
Thompson General	8,125	112	8,237	7,872	6,559	14,431
Flin Flon	216	16,713	16,929	190	52	242
Lynn Lake	1,119	3	1,112	1,190	1,802	2,992
Churchill Health Centre	175	11	186	175	588	763
Leaf Rapids	86	2	88	82	226	308
Other Hospitals and Nursing Stations	26,308	1,869	28,177	3,720	1,453	5,173
Rural Hospitals Sub-Total	39,831	28,348	68,179	13,681	10,914	24,595
Active Care Hospitals Sub-Total	81,339	34,943	116,282	32,686	16,858	49,544
Winnipeg Municipal Hospitals	380	38	418	178	155	333
Deer Lodge Centre	449	125	574	21	0	21
Manitoba Adolescent Treatment Centre	1,170	229	1,399	588	0	588
Extended Treatment Sub-Total	1,999	392	2,391	787	155	942
Combined Days: Active and Extended Treatment	83,338	35,335	118,673	33,473	17,013	50,486

Source: MHSC Hospital Table 19A (#A44I732-REP1)

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Table VI NORTHERN HEALTH FACILITY BEDS AND MHSC EXPENDITURES, 1990/91

Facility	Rated Beds	MHSC Payments	
Flin Flon Hospital	100	$6,474,072	
St. Anthony's (The Pas)	84	9,488,760	
Pukatawagan Nursing Station	4	10,005	*
Snow Lake Nursing Station	4	628,992	
Norman Region Acute Care Sub-total	192	16,601,829	
Flin Flon Personal Care Home	30	982,968	
Northern Lights Manor (Flin Flon)	30	402,144	
St. Paul's Residence (The Pas)	70	1,788,192	
Norman Personal Care Homes Sub-total	130	3,173,304	
Thompson Hospital	100	10,952,184	
Churchill Health Centre	31	3,559,912	
Lynn Lake	25	1,392,120	
Gillam	10	1,529,064	
Leaf Rapids	8	785,736	
Hodgson (P.E. Moore) Hospital	16	1,229,864	*
Norway House Hospital	16	804,932	*
Berens River Nursing Station	6	9,766	*
Bloodvein Nursing Station	2	7,757	*
Brochet Nursing Station	3	1,511	*
Cross Lake Nursing Station	4	26,527	*
Garden Hill Nursing Station	3	8,451	*
God's Lake Nursing Station	4	8,043	*
Lac Brochet Nursing Station	2	7,310	*
Little Grand Rapids Nursing Station	4	11,932	*
Nelson House Nursing Station	4	9,458	*
Oxford House Nursing Station	3	18,289	*
Poplar River Nursing Station	4	6,994	*
Red Sucker Lake Nursing Station	2	2,762	*
Ste. Theresa Nursing Station	3	19,162	*
Shamatawa Nursing Station	4	12,498	*
South Indian Lake Nursing Station	6	5,032	*
Split Lake Nursing Station	4	4,693	*
Wassagamack Nursing Station	1	5,929	*
Thompson Region Acute Care Sub-total	265	20,419,926	
Pinaow-Wachi (Norway House) Personal Care Home	26	149,080	**
Thompson Region Personal Care Home Sub-total	26	149,080	
Total Northern Acute Care and Personal Care Homes Beds	613	$40,344,139	

Source: Manitoba Health Services Commission Annual Report, 1990/91

* Additional operating and capital funds were provided to each federal facility from the Medical Services Branch, Health and Welfare Canada (See Table III).

** Additional operating and capital funds were provided from the Department of Indian Affairs and Northern Development.

NORTHERN HEALTH FACILITY BEDS AND EXPENDITURES, 1989/90

NORMAN REGION:

	Rated Beds	MHSC Payments
Flin Flon Hospital	100	$ 5,613,554
St. Anthony's (The Pas)	84	8,887,320
Pukatawagan Nursing Station	4	4,725
Snow Lake Nursing Station	4	603,528
Norman Acute Care Sub-total	192	$ 15,109,127
Flin Flon Personal Care Home (PCH)	30	941,376
Northern Lights Manor (Flin Flon)	30	418,632
St. Paul's Residence (The Pas)	70	1,670,616
Norman PCH Sub-total	130	$ 3,030,624

THOMPSON REGION:

Thompson Hospital	100	$ 10,036,416
Churchill Health Centre	31	3,327,013
Lynn Lake	25	1,327,416
Gillam	10	1,422,504
Leaf Rapids	8	718,248
Snow Lake	4	603,528
Hodgson (P.E. Moore) Hospital	16	816,560 *
Norway House Hospital	16	641,951 *
Berens River Nursing Station	6	6,301 *
Bloodvein Nursing Station	2	2,659 *
Brochet Nursing Station	3	1,982 *
Cross Lake Nursing Station	4	21,996 *
Garden Hill Nursing Station	3	5,178 *
God's Lake Nursing Station	4	622 *
Lac Brochet Nursing Station	2	9,424 *
Little Grand Rapids Nursing Station	4	3,693 *
Nelson House Nursing Station	4	11,520 *
Oxford House Nursing Station	3	13,154 *
Poplar River Nursing Station	4	3,761 *
Red Sucker Lake Nursing Station	2	1,895 *
Ste. Theresa Nursing Station	3	15,369 *
Shamatawa Nursing Station	4	7,438 *
South Indian Lake Nursing Station	6	6,281 *
Split Lake Nursing Station	4	3,025 *
Wassagamack Nursing Station	1	5,824 *
Thompson Acute Care Sub-total	273	$19,018,483
Pinaow-Wachi (Norway House) PCH	25	174,472
Thompson Region PCH Sub-total	25	$ 174,472
Total Northern Acute Care and PCH Beds	620	$37,332,706

Source: Manitoba Health Services Commission Annual Report, 1989/90

* Additional operating and capital funds were provided from the Medical Services Branch, Health and Welfare Canada ($31,754,300 [illegible]

Appendix 1

May/64

MEMORANDUM OF AGREEMENT BETWEEN THE DEPARTMENT OF NATIONAL HEALTH AND WELFARE, as presented by the Medical Services Directorate, AND THE DEPARTMENT OF HEALTH OF THE PROVINCE OF MANITOBA, as represented by the Division of Health Services.

(196A)

It is agreed that in the following areas: Moose Lake, Grand Rapids, and Cedar Lake to the southeast of The Pas, and in the Bayline communities of Cormorant, Wabowden, Sipawisk, Thicket Portage, Pikwitonei, Ilford, Gillam, and Bird, together with and including all section houses on the C.N. Railway Line as far north as Churchill, the Local Government District of Churchill and the Local Government District of Lynn Lake, the Provincial Northern Health Services would provide clinical and public health services in the field.

In the following areas: Nelson House, Pukatawagon, South Indian Lake, Brochet, Split Lake, York Landing, Shamattawa, The Pas Reserve, Norway House, Cross Lake, Oxford House, God's Lake, Island Lake, Ste. Theresa Point and Granville Lake, Medical Services of the Department of National Health and Welfare would provide clinical and public health services in the field.

In addition, it is further agreed that the individual services would supply professional and ancillary personnel to the above areas, and be responsible for their own drugs and medical supplies, although Medical Services agreed that they would continue to supply drugs to Provincial Northern Health Services at cost plus ten per cent.

The respective services would undertake fiscal responsibility for transport of staff and patients for whom they are responsible. In the case of Provincial Northern Health Services, this would apply to Non-Indian patients, and in the case of Medical Services, Department of National Health and Welfare, this would apply to Indian patients only. Each service, however, will accept fiscal responsibility for such arrangements made by the other services for a patient on behalf of the first service. For example, Medical Services will accept financial responsibility for Indian patients moved from Moose Lake to The Pas by Provincial Northern Health Services without prior authorization.

Provincial Northern Health Services will accept financial responsibility for movement of all indigent Non-Indian patients in communities served by Medical Services, Department of National Health and Welfare without prior authorization. Except in cases of emergency, it is agreed that consultation between the two services should be made whenever possible, on all movements of patients prior to such movement.

Venereal Disease Control shall remain under the Provincial Northern Health Services jurisdiction, but in the field, staff of the individual services would be responsible for location of contacts, advisory services, etc.

In the field of tuberculosis control, each service shall be responsible for its program within its own area, but there shall be a mutual interchange of information and data.

Each service will be responsible for the establishment and maintenance of communications to effect the movement of patients to and from hospital. That is, in the areas of responsibility as outlined above, Medical Services, Department of National Health and Welfare will be responsible for the necessary arrangements required to transport all patients from their communities to hospital or clinic, together with information pertaining to the patient being moved. Likewise, Provincial Northern Health Services will be responsible for identical arrangements regarding transportation of all patients in their area of operation.

Provincial Northern Health Services will undertake to provide supervision of environmental sanitation where feasible, if and when requested by Medical Services, Department of National Health and Welfare, in areas of their jurisdiction.

Zone Superintendent, Medical Services, at Norway House will be named Deputy Health Officer to the Director of Northern Health Services, and be responsible for administration of The Public Health Act in the area of his jurisdiction, under the direction of the Director of Northern Health Services.

With regard to Lynn Lake Nursing Station, if so desired that non-Indian and medical referrals be boarded elsewhere. It is agreed that with respect to the operation of Lynn Lake Nursing Station, that the Provincial Northern Health Services will base one public health nurse at this station to:

1. Provide public health services to the Lynn Lake community.
2. Make arrangements for non-Indian medical referrals.
3. Assist in the operation of the Nursing Station when both nurses are in Lynn Lake.
4. In the absence of a Medical Services field nurse, the Northern Health Services nurse will operate Lynn Lake Nursing Station, make arrangements for Indian medical referrals, and make emergency trips to outlying areas for Medical Services.

Medical Services in turn will be responsible for the operation of Lynn Lake Nursing Station. The Medical Services field nurse's duties will include:

1. Nurse in charge of Lynn Lake Nursing Station.
2. Provide public health services and minor treatment services in her area of responsibility - Brochet, South Indian Lake and environs.
3. Make arrangements for Indian medical referrals.
4. In the absence of a Provincial Northern Health Services nurse, the Medical Services nurse will also make arrangements for non-Indian medical referrals and make emergency trips for Provincial Northern Health Services upon request.
5. Assist Provincial Northern Health Services Nurse in emergencies and in large public health programs, eg. mass immunization of the community, or upon request from Provincial Northern Health Services, through The Pas Zone Superintendent.

This agreement is to be effective on the 1st day of April, 1964.

On Behalf of Medical Services Directorate,
DEPARTMENT OF NATIONAL HEALTH AND WELFARE

On Behalf of the Division of Health Services
DEPARTMENT OF HEALTH, PROVINCE OF MANITOBA

Appendix 2

FLORA ZAHARIA
Coordinator
59 SAGE CRESCENT
WINNIPEG, MANITOBA R2Y 0X8
TEL. (204) 837-4296
FAX (204) 885-4293

JOHN BURELLE
Assistant Coordinator
1101-55 GARRY STREET
WINNIPEG, MANITOBA R3C 4H4
TEL. (204) 956-0787
FAX (204) 949-9117

MOKAKIT EDUCATION RESEARCH ASSOCIATION

FIRST NATIONS FREEDOM: A CURRICULUM OF CHOICE
(ALCOHOL, DRUG AND SUBSTANCE ABUSE PREVENTION)
KINDERGARTEN TO GRADE 8

A NEW CURRICULUM

During the past two years, Mokakit Education Research Association, together with the support of NNADAP (National Native Alcohol and Drug Abuse Prevention), has developed and piloted, in twenty schools across Canada, a Drug and Substance Abuse Prevention Curriculum for Kindergarten to Grade 8. Based on the suggestions and input from parents, teachers, students and administrators, the second and final draft is presently being done and the curriculum will be made available nation-wide in August, 1992.

The title of the curriculum is -

First Nations Freedom: A Curriculum of Choice
(Alcohol, Drug and Substance Abuse Prevention)
Kindergarten to Grade 8

This national multi-media curriculum is designed:

- for First Nations Schools across Canada;
- to help students identify what constitutes healthy drug-free lifestyles and how to make balanced decisions concerning alcohol, drug and substance abuse;
- to help students attain and maintain a positive feeling of self-worth and connection with traditional values and culture.

For further information about the curriculum, please contact:

Flora Zaharia, Coordinator
59 Sage Crescent
Winnipeg, Manitoba
R2Y 0X8
Telephone: (204) 837-4296
FAX: (204) 885-4293